STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001150	A. BUILDING _____ B. WING _____	12/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA OF THE WOODS	5610 NOLL AVE FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS	R 000		

This visit was for a State Licensure Survey.

Survey date: December 19, 2011

Facility number: 001150
Provider number: 001150
Aim number: N/A

Survey team:
Angela Strass, RN TC
Rick Blain, RN
Sue Brooker , RD

Census bed type:
Residential: 11
NCC: 4
Total: 15

Census payor type:
Medicaid: 9
Private: 6
Total: 15

Sample: 6

Villa of the Woods was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey.

Quality review completed 12/20/11
Cathy Emswiller RN